Memorandum

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TO: Commonwealth of Massachusetts Health Policy Commission

FROM: Ray McCarthy, CFO Baycare Health Partners and Baystate Medical Practices
Andréa Carey, Manager, Contracting, Baycare Health Partners

DATE: May 13, 2015

RE: **Comments on the Registration of Provider Organization Draft Part 2 Data Submission Manual**

Thank you for the opportunity to review and comment on the draft Data Submission Manual (DSM) for Registration of Provider Organizations (RPO) Initial Registration - Part 2. We appreciate the changes that have been made to the DSM since the original version of April 2014. However, we have ongoing concerns regarding the type and extent of information being requested, the duplicative nature of some of the data elements, the administrative burden it is placing on provider organizations, and ultimately how the information will be used. The Health Policy Commission (HPC) is charged with developing policy to reduce health care cost growth and improve the quality of patient care. The RPO Part 2 registration process is burdensome and adds significant administrative costs to the healthcare delivery system with unclear value in the improvement in patient care. We look forward to continuing to work together to make the provider registration process accessible and meaningful, for the providers, state and community.

On behalf of Baystate Health and Baycare Health Partners, we would like to make the following comments.

Administrative Complexity and Duplication

Several sections of the DSM require detailed information that is available from other state agencies. By example, the Facilities File requests licensure information reported to the Department of Public Health (DPH); the Physician Roster File requests information on file with the Massachusetts Health Quality Partners (MHQP) and the Board of Registration in Medicine (BORIM); the Contracting Entity File requests information reportable to the Division of Insurance (DOI) for Risk Bearing Provider Organizations (RBPO). All of these reporting obligations represent significant amounts of information, requiring updates on a bi-annual or, in many cases, on an annual basis. Recognizing that the information is only accurate as of the day it is submitted, this will serve to create duplicate databases with inconsistent information. The goal should be to work on maintaining one central data repository from which all state agencies can access the applicable data.

We appreciate that Part 1 files will pre-populate Part 2, and would request that Part 2 files pre-populate each other as appropriate to reduce the need to enter duplicate information.

Timing

The proposed timetable for submission is aggressive, given the extent of the information that RPOs will need to gather. The data being collected across a large organization like Baystate Health will require interdepartmental and facility coordination. Additionally, the deadline coincides with DOI's RBPO, HPC's Patient Centered Medical Home (PCMH), fiscal year end for our hospitals and many others, HPC cost-trend hearings, and CMS Medicare Shared Savings Program (MSSP)/Next Generation Accountable Care Organization (ACO) applications, to name a few of the other significant projects. Finally, RPOs will be using a new submission platform, and we expect that there will be a learning curve for both the RPO and HPC with this tool. The proposed reporting time period includes only 42 business days, half of which fall during the peak summer months. For these reasons, we would recommend that the reporting deadline be extended through year-end, or at least through the end of October.

We appreciate the opportunity for education and training sessions, and would be happy to make Baycare's facilities in Western Massachusetts available for any proposed sessions.

Confidential and Proprietary Information

Information requested in several areas of the DSM, but most importantly related to the funds flow, is proprietary information (data elements RPO-74 to 77). We are troubled by these requests due to the public disclosure requirement, and we feel this will compromise competitive positions of RPOs and lead to possible disruption of provider alignment strategies, as well as have serious consequences to regional partnerships. Specifically, data element RPO-75, which requests RPOs to disclose those providers who are responsible for deficits, will put some entities that hold providers responsible or liable for deficits at a distinct disadvantage to those entities that absorb any risk through reserves or other vehicles that buffer, in some manner, the individual providers or practices from downside risk. In addition, we strongly believe that this data element will be adequately addressed with information the DOI is required to obtain related to the regulation focused on RBPO and the actuarial certification process. <u>We strongly request that the HPC reconsider and eliminate the reporting requirements related to funds flow due to the proprietary and confidential nature of the information.</u>

Appeals Process

The penalty for non-compliance is severe, and as a result we request that the HPC develop an appeals and resolution process for situations when the HPC determines non-compliance.

File-Specific Comments

We would also like to submit the following file-specific comments:

B. Corporate Affiliations File

Questions 56-57 are already answered on the corporate organizational chart.

Questions 58-61 - The RPO should not be accountable to report on those other entities that are NOT corporately affiliated with the RPO for the following reasons:

- Administratively burdensome to collect the information;
- Many of these entities do not fall within the oversight of the HPC;
- RPO is uncomfortable publically reporting on organizations for which we do not have corporate control or ownership
- Information that RPO reports on unaffiliated entities could have unintended consequences.

C. Contracting Affiliations File

The RPO is the contracting entity for physician group practices as well as solo physician practices. Therefore, individual physicians will be listed in the contracting affiliations file and in the physician roster file, causing duplication of information.

Question 66 – RPO should be required to report on only those contracting entities that are corporately affiliated with the RPO.

D. Contracting Entity File

Question 69 - The Contracting Entity is being asked to report on contracts for Medicare ACOs when Medicare is not included in the regulatory definition of a reportable carrier, so we believe this is outside the scope of review.

Question 70 – It will be administratively burdensome to identify the start year of each contract type for each contracting entity. This does not appear to be a statutory requirement; it is unclear why this information is necessary and what purpose it will serve.

Questions 74-77 – This information, as previously commented, constitutes confidential and proprietary information relative to how the Carriers, RPO and providers conduct

business. Public reporting of this information will 1) compromise the RPO's ability to contract successfully with provider groups; and 2) violate contractual obligations between the RPO and carriers relative to confidentiality of plan proprietary information. The DOI RBPO certification requires summary responses relative to risk-sharing; this will meet any reporting requirements of the HPC and the RPO regulation. For these reasons, we request that the HPC limit the information requested to a level of detail no greater than that represented in Questions 72 and 73 to protect sensitive and anti-competitive information from public disclosure. Alternatively, the HPC could include language that keeps confidential and does not allow for public disclosure of all non-public information obtained in this section.

Question 78 - Uploading a physician roster per Contracting Entity will produce duplicative data for any Contracting Affiliates who have more than one Entity contracting on their behalf (e.g. a hospital and a PHO).

E. Facility File

Much of the information in this section is already available on the facility licenses through the Department of Public Health (DPH). In addition, the definition of the main structure "footprint" or campus locations for larger organizations will be extensive so limiting the physical locations to those areas immediately adjacent to the main buildings or structures or within 250 yards is too limiting. We request that the HPC coordinate with DPH, as required under Chapter 224 to minimize duplicative reporting requirements that are costly and burdensome or expand the definition of main campus or footprint requirements. (i.e. in miles not yards).

F. Physician Roster File

The resources and coordination that are required to comply with the annual update of the MHQP Massachusetts Physician Database (MPD) are already extensive. Our organization currently meets the MPD annual update requirement each December by dedicating resources to review and update the data, so placing an additional burden on that process for Part 2 of the DSM is the definition of duplication. Baystate dedicates a resource to review the data annually and it takes 4-5 days for one person to complete this process. It should be the responsibility of the HPC to coordinate and utilize an already existing process and database. To meet the obligation of the regulation the HPC should simply request from RPOs that they have reviewed and validated the MHQP MPD (i.e. an attestation process). After carefully reviewing the fields already contained in the MHQP data, we would agree that many of the elements in DSM Physician Roster File are available.

Question 125 - Please clarify the definition Local Practice, as compared to Medical Group and Practice site.

G. Clinical Affiliations File

The scope of this section remains extremely broad in nature and should reflect materiality, using either a financial threshold, or an affiliation which is strategic in nature, of which the public might be generally aware in a way that might affect how they seek care (e.g. co-branding). As part of normal operations on a day to day basis, provider groups (especially physician practices) provide clinical services to other healthcare entities through moonlighting, call and coverage, and purchased service arrangement engagements. Reporting such information and those relationships as part of the Part 2 DSM process will be administratively complicated, because generally those healthcare services and arrangements for larger institutions are handled in a decentralized manner (managed at the department chair or at a division service line level). Ensuring a complete list of all these relationships would require a great deal of coordination and effort involving every area within the health system.

Additionally, in some cases the information requested may constitute confidential and proprietary information relative to how the providers conduct business. Caution should be used in where information is not currently, and should not be, made publically available. Reporting at this level could have unintended business and operational consequences.

Co-located services do not necessarily constitute a clinical affiliation other than efficiency.

Again, we appreciate the opportunity to provide written comment on Part 2 of the DSM process, and we fully understand and appreciate that there are requirements contained in CH 224 with which the HPC needs to comply. However we urge you also to be advocates for the provider community and to better understand that placing an increased administrative burden on entities that are constantly looking to remove waste, duplication and seek efficiencies in delivering healthcare services, in the most cost effective and transparent manner should also be part of the objective in meeting the legislative requirements.

If you have any questions, please contact Ray McCarthy (413.794.7944 or Raymond.mccarthy@baystatehealth.org) or Andréa Carey (413.794.9303 or acarey@baycarehealth.org).